EDMUND G. BROWN JR.
Attorney General of California
GLORIA A. BARRIOS
Supervising Deputy Attorney General
KIMBERLEE KING
Deputy Attorney General
State Bar No. 141813
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2581
Facsimile: (213) 897-2804

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **THOMAS A. BAXTER** **2600 S. Azusa Ave. #258** **W. Covina, CA 92792** **Registered Nurse License No. 460274** Respondent.	Case No. 2010-596 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about November 30, 1990, the Board of Registered Nursing (Board) issued Registered Nurse License Number 460274 to Thomas A. Baxter (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2010, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code.

STATUTORY PROVISIONS

4. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after expiration.

6. Section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

COST RECOVERY PROVISION

7. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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CAUSE FOR DISCIPLINE

(Disciplinary Action by Another State)

8. Respondent is subject to disciplinary action under section 2761, subdivision (a)(4), in that he was disciplined by the Arizona State Board of Nursing (Arizona Board), as follows:

a. On or about March 14, 1996, pursuant to Findings of Fact, Conclusions of Law and Amended Order No. 940820, in the action entitled *In the Matter of the Disciplinary Action Against Professional Nurse License No. RN071722 Issued to: Thomas A. Baxter*, the Arizona Board placed Respondent's license on suspension for an indefinite period with terms and conditions.

b. As set forth in the Findings of Fact, Respondent engaged in, including, but not limited to, the following conduct:

1. On or about June 8, 1994, Respondent applied a headlock to a Department of Corrections inmate/patient, after the patient had become agitated and violent. Respondent applied the headlock with such force that Respondent's arms were shaking and Respondent's face became red. While restraining the patient, Respondent called the patient a "scumbag."

2. On or about June 24, 1994, Respondent was attempting to bathe a patient who had been intubated and sedated. The patient became agitated and lifted her head off the bed. Respondent used the palm of his hand to push the patient's head back down onto the bed. On two more occasions, the patient lifted her head and Respondent pushed it back down with his palm. Respondent appeared to be angry with the patient. When another nurse commented on Respondent's actions, Respondent stated, "that's OK, she won't remember it." The same day, Respondent shaved the patient's entire pubic area even though a procedure to be performed on the patient (insertion of a femoral line on the patient's right side) only required that Respondent shave a portion of the patient's pubic area.

3. On another occasion in June 1994, Respondent shaved a comatose patient's beard and mustache without any medical reason or consent.

c. As set forth in the Conclusions of Law, the conduct and circumstances described in the Findings of Fact constituted violations of certain provisions of the Arizona Revised Statues

and Arizona Administrative Code, in effect at the time Amended Order No. 940820 was issued, governing unprofessional conduct, including conduct or practices that are or might be harmful or dangerous to the health of a patient or the public.

d. Respondent failed to comply with the terms and conditions of his suspension, as set forth in Amended Order No. 940820. Respondent's Arizona License No. RN071722 expired on May 31, 1998, while under suspension.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 460274 issued to Thomas A. Baxter.

2. Ordering Thomas A. Baxter to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/17/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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Exhibit A

BEFORE THE ARIZONA STATE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY ACTION AGAINST PROFESSIONAL NURSE LICENSE NO. RN071722 ISSUED TO: THOMAS A. BAXTER C/O CATHERINE McLEOD/PATRICIA GITRE ATTORNEYS AT LAW 2990 E. NORTHERN, SUITE A102 PHOENIX, ARIZONA 85028	FINDINGS OF FACT, CONCLUSIONS OF LAW AND AMENDED ORDER NO. 940820

A hearing was held before Harold J. Merkow, Hearing Officer, at the Arizona State Board of Nursing, 1651 E. Morten Avenue, Suite 150, Phoenix, Arizona, on the 21st day of November, and the 6th and 18th days of December 1995.

Janet M. Walsh, Assistant Attorney General, Civil Division, appeared on behalf of the State. The Respondent was not present but was represented by Patricia, Gitre, Attorney at Law.

Testimony and other evidence was received.

On December 28, 1995, the Hearing Officer issued Findings of Fact, Conclusions of Law and Recommendations. On January 25, 1996, the Arizona State Board of Nursing met to consider the Hearing Officer's recommendations. Based upon the Hearing Officer's recommendations and the administrative record in this matter, the Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Respondent is the holder of license number RN

071722 for the practice of nursing in the State of Arizona.

2. Respondent worked at Maricopa Medical Center as a pool nurse in 1990 and he then resigned from his position in order to enroll in chiropractic training. He returned to his employment at Maricopa Medical Center as a pool nurse sometime later in 1990 and he remained employed thereafter. Respondent worked in the Medical Intensive Care Unit (MICU).

3. In August 1991, while working at Maricopa Medical Center, Respondent was electrocuted. He suffered cardiac arrest and was hospitalized at Maricopa Medical Center. After several days of hospitalization, Respondent was released and, after a recuperation period, Respondent returned to work at Maricopa Medical Center without any restrictions.

4. Respondent did not experience any work related problems or receive any discipline after returning to work following his electrocution.

5. On June 8, 1994, Respondent was working on the night shift in the MICU at Maricopa Medical Center. One of the patients who was in the MICU on that date was a Department of Corrections inmate. The inmate was shackled at the ankles but his upper body was not restrained. At some point, the inmate became agitated and violent. The two correctional officers who were attending the inmate restrained his upper torso. Respondent went to the head of the bed, put the inmate in a headlock and restrained the

inmate. The force applied by Respondent was such that Respondent's arms were shaking and Respondent's face was red. While Respondent was restraining the inmate, Respondent called the patient a "scumbag".

6. On June 24, 1994, Respondent was on duty in the MICU and a female patient who had suffered a drug overdose was admitted. The patient was intubated and had been sedated with Versed. While Respondent was attempting to bathe the patient, the patient became agitated and began lifting her head from the bed. When the patient was in an approximate 45° angle, Respondent, appearing angry with the patient, placed his palm against her head and pushed her head back onto the bed. On two more occasions, the patient began raising her head off of the bed and, when the patient's head was raised, Respondent took his palm, placed his hand on the patient's forehead and pushed her back onto the bed. When another nurse commented on Respondent's actions, Respondent said "that's OK, she won't remember it".

7. The same patient required the insertion of a femoral line on her right side and Respondent was required to shave a portion of the patient's pubic area for insertion of the line. Instead of shaving only a portion of the patient's pubic area, Respondent shaved the patient's entire pubic area.

8. At some other time in June 1994, Respondent shaved the full beard and mustache of a comatose patient. There

was no medical reason for shaving the patient and Respondent did not obtain any consent to shave the patient.

9. The nurse manager, Donna Schmitz, was notified about Respondent's conduct during the month of June and, on June 27, 1994, she spoke to Respondent. Respondent did not deny any of the four reported incidents, he told Schmitz that he had "some personal issues" and he told her that those patient incidents may have been the manifestations of such issues. Respondent apologized for his actions and thanked Schmitz for bringing the matter to his attention. Schmitz informed her supervisor, Dawn Ferrara, about the four incidents.

10. On July 5, 1994, Respondent met with Dawn Ferrara. The allegations were reviewed with Respondent. Respondent did not deny the occurrence of the four incidents but he felt that, with the exception of pushing the patient's head into the bed, his actions were acceptable and he said that he would be more careful. Ferrara told Respondent that the allegations were serious, that his actions violated hospital rules and that his behavior was in violation of the Nurse Practice Act. Ferrara told Respondent that she felt that he needed a psychological evaluation because she did not believe that Respondent had insight into and did not appreciate the seriousness of the incidents.

11. At no time did Respondent tell either Donna Schmitz or Dawn Ferrara that his actions were a result of

his earlier electrocution.

12. Respondent was provided with a list of psychologists who could evaluate him. Respondent was told that Maricopa Medical Center required a written evaluation to be submitted and that his employment would be determined following the evaluation. Respondent was also told that the matter would be reported to the Board of Nursing.

13. Respondent's name was removed from the nursing pool and he did not work for Maricopa Medical Center after July 5, 1994.

14. A referral for evaluation was given to Respondent, which referral recited Respondent's attitude as "Tom has displayed anger & inappropriately rough behavior towards some patients..".

15. Respondent was evaluated by Linda Brewster, Ph.D., clinical psychologist on July 8, 12 and 25, 1994. Respondent reported "depression, despair and discouragement" in the last six months due to the end of a romantic relationship and his inability to continue his chiropractic training. Respondent acknowledged anger where he told Dr. Brewster that "the predominant arena where his anger would have been manifested would be at work".

16. Dr. Brewster concluded that Respondent had limited insight into his problems and behavior, that he is "quite angry and depressed at the present time", "he is sullen and somewhat angry and upset with other people, feeling they

have harmed him. He does not accept full responsibility for his low mood instead blaming other people for working against him", "he does not trust other people and feels angry that he is so alone. He harbors a great deal of anger which he is unable to express appropriately" and "In summary, Mr. Baxter is a very depressed individual who has some paranoid traits. He has difficulty dealing with his anger and this fact together with his depression and some paranoid personality traits have resulted in that anger being displaced to his patients. He tends to brood about his problems and his tendency to introversion compound that tendency".

17. Dr. Brewster recommended that Respondent be assessed for the utility of anti-depressant medication to assist in relieving his depressive symptoms, that Respondent be required to undergo psychotherapy and that Respondent be re-evaluated in four to six months.

18. After receiving Dr. Brewster's evaluation, Dawn Ferrara spoke with Respondent and told him that, because of his anger and lack of insight, he would not be allowed to return to work at Maricopa Medical Center, but, if he could demonstrate satisfactory behavior for one year with another employer and if he completed psychotherapy, he could be rehired.

19. In August 1994, Respondent obtained a pool nurse position at Good Samaritan Hospital.

20. On September 8, 1994, the Board's consultant, Jane Werth, met with Respondent to review the allegations made by Maricopa Medical Center. Respondent did not deny the occurrence of the incidents, however, he did not believe that he acted inappropriately. Respondent told Werth that he was clinically depressed, that he was trying to change his world views and that he was making an appointment with a nurse practitioner. Respondent did not tell Werth that any of his actions were due to his previous electrocution.

21. Respondent was evaluated by Kathe Reitman, psychiatric nurse practitioner, for his depression. He was placed on anti-depression medication Zoloft and was followed for medication management by Ms. Reitman through November 1994. Ms. Reitman informed the Board that "I recommend ongoing medication management and psychotherapy for difficulties which bring on depressive symptoms".

22. Dr. Brewster referred Respondent to one Jeffrey Harrison, Ph.D., clinical psychologist, for therapy. Respondent began seeing Dr. Harrison on September 27, 1994. Dr. Harrison recommended that Respondent complete a psychosexual evaluation because there was a suggestion that Respondent's behavior may have been related to sexual intent or atypical sexual interest. Respondent reported to Dr. Harrison that his behavior at Maricopa Medical Center was "very atypical and out of character for him" and he indicated that such behavior had not occurred either before or after

the incidents in June 1994. Respondent informed Dr. Harrison about his break-up with a woman with whom he was involved for 12 years and that he was "experiencing isolation, loneliness, increasing depression and anger over his circumstances in life. He also reported that his initial attempt to become a chiropractor had failed and he returned to nursing to support himself. Mr. Baxter also indicated that he was extremely unhappy and embarrassed by being a nurse and had experienced an inability to nurture and be a caretaker for his patients".

23. Dr. Harrison's treatment goals included developing an understanding and alleviation of Respondent's anger and depression, resolving his problems with the Board and making environmental adjustments to his life "that would help him feel more balanced, both personally and professionally".

24. Respondent continued to treat with Dr. Harrison until December 1994 when Respondent left Arizona and moved to California. Dr. Harrison reported that Respondent "made a very positive response to treatment" but indicated that continued treatment is necessary "for him to continue his work and achieve all of the goals that were identified".

25. At the time Respondent ceased treatment with Dr. Harrison, it was believed that Respondent did not present any significant risk for physical aggression or acting out with patients. Dr. Harrison believed that "A likely explanation for the episodes is that Mr. Baxter converted

his feelings of depression, frustration and anger over multiple failures of his relationship, stress and occupational frustration into externally directed acts of aggression towards his patients. Should he attend to those issues and address his characterologic and emotional functioning, the misbehavior is not likely to repeat".

26. In January 1995, the matter was presented to the Board. At that time, Respondent had not completed the psychosexual evaluation and the Board deferred consideration of the matter until such evaluation was completed.

27. Respondent completed the psychosexual evaluation and Respondent also submitted to a polygraph examination. Dr. Harrison concluded that Respondent was not experiencing any underlying sexual disorder.

28. The matter was addressed by the Board again at its April meeting. By that time, Dr. Harrison had submitted a written report in which he recommended that Respondent continue in therapy to address the characterological and emotional problems that have contributed to the episode, that Respondent engage in behaviors that would allow him to be successful in multiple areas of his life and that Respondent take additional training in ethics pertaining to patient care.

29. Jane Werth spoke with Dr. Harrison shortly before the Board's April 1995 meeting. During that conversation, Dr. Harrison told Werth that he believed that Respondent's

actions were caused by physical, rather than sexual, aggression and that Respondent continued to need to work on character issues. Dr. Harrison did not say anything to Werth about Respondent's behaviors being as a result of Respondent's earlier electrocution.

30. Respondent did not accept the Board's suggested disciplinary action and the matter was then scheduled for hearing, which hearing was set for November 21, 1995. At the designated time and place set for hearing, neither Respondent nor his attorney appeared. The matter was continued by the undersigned, on his own motion, and the hearing was rescheduled to December 6, 1995, at which time Respondent did not appear, however his attorney appeared. The hearing was continued to December 18 because it was not completed on December 6, however Respondent did not appear at the hearing although his attorney appeared.

31. There is no evidence in the record of this matter to show that Respondent has been involved in any psychotherapy since December 1994 "to address the characterological and emotional problems" as had been recommended by Dr. Harrison.

32. There is no evidence in the record of this matter to show that Respondent has been taking Zoloft or any other anti-depressive medication since December 1994. Further, there is no evidence in the record of this matter to show that Respondent has been involved in any ongoing medication

management for difficulties which bring on depressive symptoms as had been recommended by Kathe Reitman.

33. There is no evidence in the record of this matter to show that Respondent has taken any courses in nursing ethics pertaining to patient care at any time as had been recommended by Dr. Harrison.

34. There is no evidence in the record of this matter to show that Respondent has engaged "in behaviors that would allow him to be successful in multiple areas of his life, including educational, occupational, interpersonal and also managing stress, anger and frustration" as recommended by Dr. Harrison.

35. Because there is no evidence to show that Respondent has been involved in psychotherapy, there is no evidence in the record of this matter to show that Respondent does not present any significant risk for physical aggression or acting out with patients.

36. Because there is no evidence to show that Respondent has been involved in psychotherapy, there is no evidence in the record of this matter to show that Respondent will not convert "his feelings of depression, frustration and anger over multiple failures of his relations, stress and occupational frustration into externally directed acts of aggression towards his patients".

37. There is no evidence in the record of this matter

to support any claim that Respondent's conduct in June 1994 was related, in any way, to his earlier electrocution since he was released to return to work on September 1, 1991, without any restrictions, he received a satisfactory evaluation in October 1991 which evaluation did not show any performance impairment and his June 1993 physical examination did not show any emotional or physical problems.

38. There is no evidence in the record of this matter to support any claim that Respondent's conduct in June 1994 was related, in any way, to his earlier electrocution since there is no evidence that Respondent engaged in any aggressive or abusive behavior with patients prior to June 1994, Respondent's work hours were not restricted in any way and Respondent was able to work a considerable number of overtime hours.

39. There is no evidence in the record of this matter to show that any long term effects from electrocution cause nurses to become physically abusive with their patients.

40. There is no evidence in the record of this matter to show that any long term effects from electrocution cause nurses to become depressed, frustrated or angry to the point where the nurses become physically abusive with their patients.

41. There is no evidence in the record of this matter to show that any long term effects from electrocution cause personality alterations to nurses whereby the nurses become

physically abusive with their patients.

42. There is no evidence in the record of this matter to show that, since December 1994, Respondent has been employed, in any capacity, in the profession of nursing.

43. There is no evidence in the record of this matter to show that, prior to June 1994, Respondent engaged in any abusive behavior towards the patients for whom he was providing care.

44. There is no evidence in the record of this matter to show that, after June 1994, Respondent engaged in any abusive behavior towards the patients for whom he was providing care.

CONCLUSIONS OF LAW

1. This matter is within the jurisdiction of the Arizona State Board of Nursing pursuant to ARS, §32-1601 et. seq., and the regulations promulgated thereunder.

2. All due process rights to which Respondent is entitled have been met.

3. Respondent's actions on June 8, 1994, whereby Respondent applied a headlock to a patient at Maricopa Medical Center with such force that his, Respondent's, arms began shaking and his face became red, constitute unprofessional conduct within the meaning of A.A.C. R4-19-403 (1) which therefore constitute violations of ARS, §32-

1601 11. (d).

4. Respondent's actions on June 8, 1994, whereby, when applying a headlock to a patient at Maricopa Medical Center, Respondent referred to the patient as a "scumbag", constitutes a violation of A.A.C. R4-19-403 (1) which therefore constitutes a violation of ARS, §32-1601 11. (d).

5. Respondent's actions on June 24, 1994 whereby Respondent, using the palm of his hand, pushed the head of a female patient to the bed when the patient tried, on three occasions, to lift her head off of the bed, constitute violations of A.A.C. R4-19-401 (1) which therefore constitute violations of ARS, §32-1601 11. (d).

6. Respondent's actions on June 24, 1994 whereby, after pushing the head of a female patient three times to prevent her from raising her head off of the bed, told another nurse that that procedure was all right because the patient would not remember his behavior, constitute violations of A.A.C. R4-19-403 (1) which therefore constitute violations of ARS, §32-1601 11. (d).

7. Respondent's actions on June 24, 1994, whereby Respondent shaved the entire pubic area of a female patient for whom a femoral line was to be placed on her right side constitutes a violation of A.A.C. R4-19-403 (1) which therefore constitutes a violation of ARS, §32-1601 11. (d).

8. Respondent's actions during the month of June 1994 whereby Respondent shaved the full beard and mustache of a

comatose patient, without medical justification and without consent, constitutes a violation of A.A.C. R4-19-403 (1) which therefore constitutes a violation of ARS, §32-1601 11. (d).

9. Respondent's failure to complete psychotherapy with Dr. Harrison due to his relocation to the State of California in December 1994, which cessation of therapy prevented Respondent from achieving his therapy goals of understanding and alleviating his anger and depression and making environmental adjustments to his life that would help him feel more balanced, both personally and professionally, constitutes a violation of ARS, §32-1601 11. (d) and (f).

10. Respondent's failure to complete psychotherapy with Dr. Harrison due to his relocation to the State of California in December 1994, which cessation of therapy prevented Respondent from adhering to the recommendations of Dr. Harrison that Respondent continue therapy "to address the characterological and emotional problems: that contributed to his June 1994 behavior, constitutes a violation of ARS, §32-1601 11, (d) and (f).

ORDER

In view of the above Findings of Fact, Conclusions of Law and the Consent of Respondent, the Board hereby issues the following Order:

Respondent's license is placed on suspension for an indefinite period with terms and conditions, followed by probation for twenty-four (24) months while employed in nursing (not less than sixteen (16) hours a week) or until such time as

Respondent has worked as a professional nurse in a probationary status for twenty-four (24) months. The Suspension is to commence the effective date of this Order and is subject to the following conditions:

TERMS OF SUSPENSION

1. Surrender of License

Respondent agrees to immediately surrender Respondent's license to the Board and will not practice nursing for an indefinite period.

2. Psychological Counseling

The Respondent shall, within ten (10) days of the effective date of the Order, submit the name of a Board-certified psychologist that will be conducting psychotherapy with the Respondent. The Respondent shall immediately execute appropriate release of information forms so the therapist shall immediately submit to the Board, in writing on letterhead, a summary of any previous evaluations testing and verification of number of sessions attended, frequency of sessions and areas of concentration in the counseling. Respondent must demonstrate participation in psychotherapy on an ongoing basis to address characterologic and emotional problems that contributed to Respondent's physically abusive and demeaning actions toward patients in June 1994. The Respondent must also demonstrate through reports from the counselor, that he does not present any significant risk for physical aggression in acting out with patients.

The treating psychologist must submit reports, in writing on letterhead, every three (3) months documenting Respondent's progress in therapy. Respondent shall continue in therapy until the psychologist notifies the Board in writing, on letterhead, that therapy is no longer needed. The Board may amend the Order based on reports from the psychologist.

3. Ethics Course

Before Suspension can be completed, Respondent must show written documentation to the Board or its designee of successful completion of a course in ethics pertaining to patient care and specifically, recognizing and respecting patient boundaries.

4. Obey all Laws

Respondent shall obey all federal, state and local laws, and all law/rules governing the practice of nursing in this state.

5. Interview with the Board or its Designee

Respondent shall appear in person for interviews with the Board or its designee upon request at various intervals and with reasonable notice.

6. Change of Employment/Personal Address/Telephone Number

Respondent shall notify the Board, in writing, within one (1) week of any change in employment, personal address or telephone number.

7. Renewal of License

In the event the license is scheduled to expire during the period of suspension, Respondent shall apply for

renewal of the license, pay the applicable fee, and otherwise maintain qualification to practice nursing in Arizona.

8. Release of Information Forms

Respondent shall immediately execute all release of information forms as may be required by the Board or its designee.

9. Violation of Suspension

If Respondent violates suspension in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke Respondent's license or take other disciplinary action. If a complaint is filed against Respondent during suspension, the Board shall have continuing jurisdiction until the matter is final, and the period of suspension shall be extended until the matter is final.

10. Voluntary Revocation of License

Respondent may, at any time this Order is in effect, voluntarily request revocation of his license.

11. Completion of Suspension

Before completing suspension, Respondent must provide the Board or its designee with evidence of successful completion of an ethics course and evidence of participation in ongoing psychotherapy to address characterologic and emotional problems that contributed to Respondent's physically abusive and demeaning actions toward patients in June 1994. The Respondent must also demonstrate that he has obtained a therapeutic status equivalent to the state of therapy completed in December 1994 which evidence must demonstrate the Respondent does not present

any significant risk for physical aggression or acting out with patients. After presenting evidence of successful completion of all stipulations of suspension, Respondent's license will be placed on a twenty-four (24) month probation with terms and stipulations.

If the Respondent fails to provide written evidence of unsuccessful completion of suspension stipulations by July 1996, the Board shall revoke Respondent's license to practice nursing in Arizona.

TERMS OF PROBATION

1. Obey All Laws

Respondent shall obey all federal, state and local laws, and all law/rules governing the practice of nursing in this state.

2. Interview with the Board or its Designee

Respondent shall appear in person for interviews with the Board or its designee upon request at various intervals and with reasonable notice.

3. Stamping Of License

Upon successful completion of suspension, Respondent shall be issued a license stamped "PROBATION."

4. Out-of-State Practice/Residence

Before any out-of-state practice or residence can be credited toward fulfillment of these terms and conditions, they must first be approved by the Board prior to leaving the state. If Respondent fails to receive such approval before leaving the state, none of the time spent out of state will be

credited to the fulfillment of the terms and conditions of this Order.

5. Psychological Counseling

Respondent shall continue to direct the treatment professional to submit reports, in writing on letterhead, to the Board or its designee documenting the Respondent's progress in therapy. Respondent shall continue in therapy until the psychologist notifies the Board, in writing on letterhead, that therapy is no longer needed. The Board may amend the Order based on recommendations of the treatment professional.

6. Change of Employment/Personal Address/Telephone Number

Respondent shall notify the Board, in writing, within one (1) week of any change in nursing employment, personal address or telephone number.

7. Notification of Practice Settings

All current and future settings in which the Respondent practices nursing shall be promptly provided with a copy of the Board Order and informed of the probationary status. Within ten (10) days of Respondent's employment on probationary status, Respondent shall cause the immediate supervisor to inform the Board, in writing and on employer letterhead, acknowledging receipt of a copy of the Findings of Fact, Conclusions of Law and the Order and ability to comply with the conditions of probation. In the event Respondent is attending a nursing program, Respondent shall provide a copy of the Order to the Program Director. Respondent shall cause the Program Director to inform

the Board, in writing and on school letterhead, acknowledging receipt of a copy of the Order and ability of the program to comply with the conditions of probation during clinical experiences.

8. Quarterly Reports

Beginning three (3) months after the effective date of this Order, and quarterly thereafter, Respondent shall cause every employer Respondent has worked for during the quarter to submit to the Board, in writing, satisfactory employer evaluations, on the Board-approved form. In the event Respondent is not employed in nursing, or attending school, during any quarter or portion thereof, Respondent shall submit to the Board, in writing, a self-report describing other employment or activities, on the Board-approved form.

9. Practice Under Direct Supervision

Respondent shall practice only under the direct supervision of a registered nurse in good standing with the Board of Nursing. The supervising nurse should be primarily one (1) person.

10. Registry Work Prohibited

Respondent may not work for a nurse's registry, traveling nurse agency, any other temporary employing agencies or float-pool during the period of probation, unless prior approval of the Board for "direct supervision" has been granted.

11. Prohibited Hours of Work

Shall work only the day or evening shift and shall not work more than three (3) consecutive 12-hour shifts in

seven (7) days, and shall not work more than forty (40) hours in one (1) week during this probationary period.

12. Renewal of License

In the event the license is scheduled to expire during the period of probation, Respondent shall apply for renewal of the license, pay the applicable fee, and otherwise maintain qualification to practice nursing in Arizona.

13. Reevaluation of Conditions

In the event Respondent does not work in nursing within two (2) years of the effective date of this Probation, Respondent may appear before the Board for reevaluation of the probationary conditions.

14. Release of Information Forms

Respondent shall immediately execute all release of information forms as may be required by the Board or its designee.

15. Violation of Probation

If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and take further disciplinary action. If a complaint or petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

17. Voluntary Revocation of License

Respondent may, at any time this Order is in effect, voluntarily request revocation of his license.

18. Completion of Probation

Upon successful completion of probation, the Respondent shall request formal review by the Board and after formal review by the Board, Respondent's nurse license may be fully restored by the appropriate Board action if compliance with the Board Order has been demonstrated.

19. Costs

Respondent shall bear all costs of complying with this Order.

Any application for rehearing shall be made within ten (10) days pursuant to A.R.S. 32-1665.

DATED this 14th day of March, 1996.

ARIZONA STATE BOARD OF NURSING

S E A L

Joey Ridenour R.N. M.N.

Joey Ridenour, R.N., M.N.
Executive Director

JR/JW:mw

ORIGINAL mailed this 22nd day of March, 1996, by Certified Mail No. P 582 823 606 and First Class Mail to: Thomas A. Baxter, c/o Catherine McLeod/Patricia Gitre, Attorneys at Law, 2990 E. Northern, Suite A102, Phoenix, AZ 85028

COPY of the foregoing mailed this 22nd day of March, 1996, to: Janet M. Walsh, Assistant Attorney General, Civil Division, Attorney General's Office, 1275 West Washington, Phoenix, AZ 85007

By: Melanie E. Woods
Legal Secretary